MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06884 P

94a

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:

County ..... Carroll

City or town ..... Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ..... 6 mos

Hospital, Institution, or street address where death occurred: Springfield State Hosp.

How long in hospital or institution? ..... 6 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... Md County .....

City or town ..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war V

3. (a) FULL NAME Mary Regina Andrew.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: John Oliver Andrew

6.(c) If alive, give age ..... 49 years

7. Birth date of deceased (mo., day, yr.) Dec 25 1869

8. AGE: Years 77 | Months 7 | Days 6 | If less than one day ..... hrs. ..... min.

9. Birthplace ..... Baltimore, Md.
(Town, county, and state)

10. Usual occupation ..... housewife

11. Industry or business ..... at home

FATHER 12. William Jefferson Martin

13. Birthplace ..... Balto

MOTHER 14. Maiden name ..... Alice Spicer

15. Birthplace ..... Balto. Md

16. Informant ..... Mrs Marie Hamill

Address ..... St Dunstans Garth

17. Burial (Burial, cremation, or removal) Date thereof Aug. 6-47 (month) (day) (year)

Cemetery or crematory ..... St. Peters

Location ..... Bush & Bentalou

18. Funeral director ..... John A. Foran

Address ..... 3000 E. Balto St

19. Aug 5 1947 (Date rec'd by registrar) C. W. Dedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ..... Aug 4th 1947, at 8-40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26 1947, to Aug 4th 1947

and that I last saw her alive on Aug 4th 1947

Immediate cause of death	DURATION
Coronary Occlusion	1 hr
Due to Cerebral Arterio Sclerosis	10 yrs
Due to Hypertension	18 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. Wastun MD M. D. or other

Address Sykesville Md. Date signed 8/4/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06885

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 72

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster, R.D.1 Myers District.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster, R.D.1 Myers District
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Howard Lafayette Bechtel

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Lillie (Null) Bechtel
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): May 10 1873

8. AGE: Years	Months	Days	If less than one day
74	2	22	hrs. min.

9. Birthplace: Carroll County, Md. (Town, county, and state)
10. Usual occupation: Farming
11. Industry or business: Farm

FATHER
12. Name: Henry Bechtel
13. Birthplace: Carroll County, Md.

MOTHER
14. Maiden name: Martha Rebecca Bowersox
15. Birthplace: Carroll County, Md.

16. Informant: Kenneth R. Bechtel
Address: Westminster, Md. R. D. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/5/47 (month) (day) (year)
Cemetery or crematory: St. Bartholomew Cemetery,
Location: York County, Pa.

18. Funeral director: J. W. Little & Son
Address: Littlestown, Pa. Per P. A. Little

19. Aug. 4th. 1947 (Date rec'd by registrar) Calvin T. Bankert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 2 1947, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1946 to Aug 2 1947
and that I last saw h[illegible] alive on Aug 2 1947

Immediate cause of death	DURATION
a. Coronary Occlusion	1 hr
Due to: a. Arterio sclerosis & hypocardial degeneration	
Due to: b. Congestive decompensation	1 mo
Other conditions: Hypertrophy Hospital	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: injured at work?

23. SIGNATURE: W. Glenn Speicher M. D. or other
Address: Westminster Md. Date signed: 8/4/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

06886

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Hampstead (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Hampstead Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Julia A. Belt

3.(b) Social Security Number:

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Andrew J Belt
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): August 22 - 1857
8. AGE: Years: 90 Months: - Days: 9 If less than one day: hrs. min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business:
FATHER 12. Name: John Keak
13. Birthplace: Germany
MOTHER 14. Maiden name: Magdalena Braw
15. Birthplace: Germany
16. Informant: Mrs Frank Shriegall
Address: Hampstead Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 2/47 (month) (day) (year)
Cemetery or crematory: St Pauls
Location: Arcadia Md
18. Funeral director: Edw Clifton
Address: Hampstead Md
19. Sept 2 1947 (Date rec'd by registrar) John S. Hughes Jr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 31 1947, at 1:10 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 26 1947, to Aug. 31 1947
and that I last saw her alive on Aug. 31 1947

	DURATION
Immediate cause of death: Congestive Heart Failure	4 weeks
Due to: Hypertension and Cardio-Vascular Disease	10 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Maurice C. Pattenfield M. D. or other
Address: Hampstead Md Date signed: 9-1-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06887

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll
City or town Henryton, Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2mos. 3 wks. 5 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Henryton
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Washington (P.O.) (If outside city or town limits, write RURAL and give nearest town)
Street No. 5404 Sheriff Rd. N.E. (If rural, give LOCATION)
2.(a) If veteran, name war World War 1

3. (a) FULL NAME Samuel Bolling
3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Married

6.(b) Name of husband or wife Katie Bolling
6.(c) If alive, give age 52 years
7. Birth date of deceased (mo., day, yr.) NOV.22,1889

8. AGE:	Years	Months	Days	If less than one day
57	57	9		hrs. min.

9. Birthplace Mississippi (Town, county, and state)
10. Usual occupation Retired Goverment Employee
11. Industry or business

FATHER
12. Name William Bolling
13. Birthplace Mississippi

MOTHER
14. Maiden name Elmira Simmons
15. Birthplace Mississippi

16. Informant Patient
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 26, 1947 (month) (day) (year)
Cemetery or crematory Arlington National
Location Arlington Virginia
18. Funeral director Henry S. Washington & Sons
Address 467 N St. N.W. Wash. D.C.
19. Auguat 22 19 47 (Date rec'd by registrar) Albert R. Swankhan Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 19 47 at 3:30A. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27, 19 47 to August 22 19 47 and that I last saw him alive on August 22 19 47

Immediate cause of death Pulmonary Tuberculosis — DURATION Sept. 1940
Due to
Due to
Other conditions (include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Address Henryton, Md. Date signed 8/22/47

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06888

57d

Reg. Dist. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster Md. Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 y.
Hospital, institution, or street address where death occurred:
near Manchester Md.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster Md Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Near Manchester Md
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Harry Cleveland Bollinger

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Hattie V. Bollinger. 6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.): July 8, 1889

8. AGE: Years: 58 Months: 1 Days: 22 If less than one day: ....hrs. ....min.

9. Birthplace: Rayville Md (Town, county, and state)
10. Usual occupation: Cigar maker
11. Industry or business: General.
12. FATHER Name: George Bollinger
13. FATHER Birthplace: Maryland
14. MOTHER Maiden name: Eliza Wilhelm
15. MOTHER Birthplace: Maryland
16. Informant: Mrs. Hattie Grove Bollinger
Address: Westminster Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 3 1947 (month) (day) (year)
Cemetery or crematory: Union Cemetery
Location: York St Manchester Md
18. Funeral director: David R. Martin
Address: Manchester Md
19. Sept 2 1947 (Date rec'd by registrar) Mrs M. P. S. Denver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 30 1947 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1943 to Aug 30 1947 and that I last saw h alive on Aug 30 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	4 hrs
Due to: Tumor of Brain.	?
Due to: Unknown if benign or malignant. Was not operated upon. (9/24/1947)	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: Jos. E. Bush M.D. M. D. or other
Address: Hampstead Md. Date signed: 8-30-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06889

138

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years, 15 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 24 Main Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: OSCAR BOND

3.(b) Social Security Number: 218-03-7629

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 3, 1892

8. AGE: Years: 55 | Months: 6 | Days: 11 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Unity, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Charles Bond
13. Birthplace: Unknown

MOTHER
14. Maiden name: Annie Hall
15. Birthplace: Unknown

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/18/47 (month) (day) (year)
Cemetery or crematory: Western Star Cem.
Location: Catonsville, Md.

18. Funeral director: Mrs. Frances H. Hemsley
Address: 578 W. Biddle St

19. 8/14 (Date rec'd by registrar) 19 47 Albert R. Sandbach Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14, 19 47 at 1.10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29, 19 43 to Aug. 14, 19 47 and that I last saw him alive on August 14, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Md. Date signed: 8/14/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06890

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 5 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1419 E. Madison Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JOHN MATHEWS BOYCE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 5, 1927

8. AGE: Years	Months	Days	If less than one day
20	5	10	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business:

FATHER — 12. Name: Donald Boyce

13. Birthplace: West Indies

MOTHER — 14. Maiden name: Wilhelminia Griffin

15. Birthplace: West Indies

16. Informant: Patient

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 18 1947 (month) (day) (year)

Cemetery or crematory: Arbutus Memorial Park

Location:

18. Funeral director: Robert L. Young

Address: 1216 E. Caroline St.

19. 8/15 1947 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15, 1947, 12.40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10, 1947 to Aug., 15 1947 and that I last saw him alive on August 15, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Swan, M.D. M. D. or other

Address: Henryton, Md Date signed: 8/15/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06891

93d

Reg. Dist. No. 77

1. PLACE OF DEATH

County Carroll

City or town Greenmount Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Greenmount Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Anna May Brodbeck.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife John H. Brodbeck

6.(c) If Deceased ... years

7. Birth date of deceased (mo., day, yr.) December 8, 1879

8. AGE: Years	Months	Days	If less than one day
68	8	23	... hrs. ... min.

9. Birthplace Greenmount Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home.

FATHER
12. Name Thomas M. Bosley
13. Birthplace Maryland.

MOTHER
14. Maiden name Anna Williams
15. Birthplace Maryland

16. Informant Harry T. Brodbeck
Address Greenmount, Md

17. Burial Date thereof 9-3-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location Greenmount, Md.

18. Funeral director Jacob Wirtz Sons

Address Manchester Md.

19. Sept 2 1947 John S. Hughes Jr. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1947, at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1947, to August 31 1947

and that I last saw h.. alive on August 30 1947

Immediate cause of death	DURATION
Chronic Myocarditis	7
Due to Arterio-sclerotic Cardio-Vascular	
Due to Disease.	
Other conditions Senile Dementia.	4 Wks

(Include pregnancy within 3 months of death)

Major findings of operation —

Date of op. ...

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury ... Injured at work?

23. SIGNATURE Joseph E. Buck M.D.
M. D. or other

Address Westminster Md. Date signed 8-31-47

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06892

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 mos. 20 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Dorchester

City or town: Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. 23 Douglas Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Norman Brown

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): October 8, 1924

8. AGE: Years	Months	Days	If less than one day
22	10	18	hrs. min.

9. Birthplace: Cambridge, Md. (Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business

FATHER 12. Name: John Brown

13. Birthplace: Madison, Maryland

MOTHER 14. Maiden name: Ethel King

15. Birthplace: Madison, Maryland

16. Informant: John Brown- Father

Address: 23 Douglass St. Cambridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-30-47 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Cambridge Md

18. Funeral director: Lewis J. Bayne

Address: Cambridge Md

19. August 26 1947 (Date rec'd by registrar) Alfred R. Swanborn Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26 1947 at 7:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 6 1946, to August 26 1947

and that I last saw him alive on August 26 1947

	DURATION
Immediate cause of death: PProgressive Primary sTbc.	June 1944
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben W Inman M.D. M. D. or other

Address: Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06893

8 3a

CERTIFICATE OF DEATH

Reg. Dist. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Florence Crabbs

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife William Crabbs

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1881

8. AGE: Years 66 | Months 2 | Days 21 | If less than one day hrs. min.

9. Birthplace md

(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER 12. Name John Slimmer

13. Birthplace md

MOTHER 14. Maiden name Margaret Fillinger

15. Birthplace md

16. Informant William Crabbs md

Address Union Bridge md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/10/47 (month) (day) (year)

Cemetery or crematory mt Union

Location Union Bridge Rural

18. Funeral director C. O. Bussard Sons

Address Taneytown md

19. Aug 9 1947 (Date rec'd by registrar) Lucie D. Robb Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1947, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 7 1947 to Aug 7 1947

and that I last saw h alive on Aug 7 1947

Immediate cause of death Cerebral Hemorrhage — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Mosher M.D. M. D. or other

Address Union Bridge Md Date signed Aug 9 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06894

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 4 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Skedmore, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. 2, Box 54, (Annapolis, Md.)
(If rural, give LOCATION)
2.(a) If veleran, name war

3.(a) FULL NAME: ELLA VIRGINIA CROMWELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): October 3, 1931

8. AGE:

Years	Months	Days	If less than one day
15	10	7	hrs. min.

9. Birthplace: Annapolis, Md. (Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business

FATHER
12. Name: Abraham Cromwell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Etta Hayes
15. Birthplace: Maryland

16. Informant: Etta Cromwell
Address: R.F.D, Box 54, Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 13-47 (month) (day) (year)
Cemetery or crematory: Broadneck
Location: St Margarets Md
18. Funeral director: J B Johnson
Address: Annapolis, Md.

19. 8/10 (Date rec'd by registrar) 19 47 Albert R. Swarthout Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10, 19 47, at 12.15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6, 19 47 to Aug., 10 19 47 and that I last saw her alive on August 10 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md Date signed 8/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
AUG 13 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06895

48a

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:

County Carroll

City or town Manchester Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life.

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Manchester. Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Helen LaRue Earhart.

3.(b) Social Security Number 213-05-1578

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife Norman DeWitt Earhart. 6.(c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) February 19, 1914

8. AGE: Years	Months	Days	If less than one day
33	5	25	..... hrs. ..... min.

9. Birthplace Manchester Maryland (Town, county, and state)

10. Usual occupation House wife

11. Industry or business Home.

FATHER — 12. Name Howard H. Lantz

13. Birthplace Maryland

MOTHER — 14. Maiden name Anna Virginia Hively

15. Birthplace Maryland.

16. Informant Norman DeWitt Earhart

Address Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-10-47 (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Manchester Md

18. Funeral director Jacob Wink & Sons

Address Manchester Md

19. Aug. 9 1947 (Date rec'd by registrar) Mrs. H. P. S. Demmer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1947, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 11 1944, to August 8 1947 and that I last saw h.e.r. alive on August 7 1947

Immediate cause of death	DURATION
Generalized Carcinomatosis	?
Due to Primary Carcinoma of Cervix	?
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Cervix

Date of op. Oct 12-44

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE Jacob E. Burns M.D. M. D. or other

Address Manchester Md Date signed 8-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

06896

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 174 E. Green St.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: George W. Frizell

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Mary E. Frizell

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): December 18, 1862

8. AGE: Years	Months	Days	If less than one day
84	8	6	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Publisher (retired)

11. Industry or business:

FATHER — 12. Name: John Frizell

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Caroline Wright

15. Birthplace: Maryland

16. Informant: Mrs. Harry C. Bond

Address: Washington, D. C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 8/27/47 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 8-27-47 (Date rec'd by registrar) 19.... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 24 19 47, at 5p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about Sept. 1st 19 41, to Aug. 24 19 47

and that I last saw him alive on Aug. 24th 19 47

Immediate cause of death	DURATION
Chronic Myocarditis	6 years?
Due to Arterio-sclerosis	
Due to senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Billingslea M.D. M. D. or other

Address: Westminster, Md. Date signed 8-25-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06897

CERTIFICATE OF DEATH

528

80

Reg. Diat. No.

1. PLACE OF DEATH:
County: Carroll
City or town: Medford
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Medford
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Thomas Gibbs Garland

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Jane Garland
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 16 - 1859

8. AGE:

Years	Months	Days	If less than one day
88	0	26	hrs. min.

9. Birthplace: Mitchell County, N. C.
(Town, county, and state)

10. Usual occupation: Farmer Retired

11. Industry or business:

FATHER
12. Name: Lewis Garland
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Rhoda Honeycutt
15. Birthplace: North Carolina

16. Informant: Jess Garland
Address: Medford, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 13-47 (month) (day) (year)
Cemetery or crematory: Lutheran Cemetery
Location: Bachmans Valley, Md.

18. Funeral director: H. W. Hartsuff & Sons
Address: Union Bridge & New Windsor, Md

19. Aug 12 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 11, 1947, at 9:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10, 1947, to Aug 10 1947 and that I last saw him alive on Aug 10, 1947

Immediate cause of death	DURATION
Acute Cardiac Dilatation	12 hrs
Due to: Chronic myocarditis	3 yrs
Due to: Carcinoma of Bladder	6 mos
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas R Fouty M.D.
M.D. or other
Address: Westminster Md Date signed: 8-12-47

M

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VS-AT15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

06898

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

BC

CERTIFICATE OF DEATH

Reg. Diat. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs 5 mos 12 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 3 yrs 1 mo 12 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. Unknown (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Sarah C Garrick

3.(b) Social Security Number

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 18th 1866

8. AGE: Years: 81 Months: 2 Days: 4 If less than one day: hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: housework

11. Industry or business:

FATHER 12. Name: Henry a McCleary

13. Birthplace: at home

MOTHER 14. Maiden name: Mary C Tipton

15. Birthplace: Md

16. Informant: Mrs Mary E Weber

Address: 512 Gilsa St. Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-23-47 (month) (day) (year)

Cemetery or crematory: Mt Olivet cemetery

Location: Balto. Md.

18. Funeral director: William Cook Inc

Address: 1217 St Paul St.

19. Aug 20 1947 C Henry Edes Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 19th 1947 at 10-45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7th 1947 to Aug 19th 1947 and that I last saw h-- alive on Aug 19th 1947

Immediate cause of death: Bronchial Pneumonia — DURATION: 3 da

Due to: Chronic Myocarditis — 4 yrs

Due to: Senile Arteriosclerosis

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W J Gastrow M.D. M. D. or other

Address: Sykesville Md Date signed: 8/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

06899

Reg. Dist. No. 81

1. PLACE OF DEATH:
County Carroll
City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William E. Gilbert

3.(b) Social Security Number 213-03-1037

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of ~~husband or~~ wife: Sadie C. Gilbert
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Sept. 15 - 1881
8. AGE: Years 65 Months 11 Days 10 If less than one day ..... hrs. ..... min.
9. Birthplace: Frederick County, Md (Town, county, and state)
10. Usual occupation: Cement Plant Employee
11. Industry or business:
FATHER 12. Name: Clay Gilbert
13. Birthplace: Maryland
MOTHER 14. Maiden name: Adalaide McClain
15. Birthplace: Maryland
16. Informant: Sadie C. Gilbert
Address: Union Bridge, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 28-47 (month) (day) (year)
Cemetery or crematory: Lutheran Cemetery
Location: Uniontown, Md
18. Funeral director: H. H. Hartzler & Sons
Address: Union Bridge & New Windsor, Md
19. Aug 27 1947 (Date rec'd by registrar) C. Eichman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 26 1947, at 1 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 30-1945 1947 to Aug 26 1947 and that I last saw h~~im~~er alive on Aug 26 1947

	DURATION
Immediate cause of death: Chronic myocarditis	
Due to: Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE D. N Legg M. D. or other
Address Union Bridge Date signed 8-28-47

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

182 06900

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 106 E. Green St.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: HARRY K GILES

3.(b) Social Security Number: 216-22-8635

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 23, 1891

8. AGE: Years	Months	Days	If less than one day
56	1	0	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Hotel clerk
11. Industry or business:

FATHER
12. Name: John T. Giles
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Katherine Kelly
15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Margaret Reynolds
Address: Baltimore, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 8/26/47 (month) (day) (year)
Cemetery or crematory: Cathedral Cemetery
Location: Baltimore, Md.

18. Funeral director: Chas. F. Evans
Address: Baltimore, Md.

19. 8/23 1947 (Date received by registrar) Registrar

MEDICAL CERTIFICATION Prior to

20. DATE OF DEATH: August 23 1947, at 8:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Suffocation	
Due to: Epilepsy. - Had an epileptic seizure while lying face down, with	
Due to: his face in feather pillow - on	
Aug. 23, 47 at his home - Westminster [10:7:47 cm]	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James T. Marsh, Deputy Medical Examiner
M. D. or other
Address: Westminster Md Date signed: 8/28/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06901

932

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll Co.

City or town: Rural near Westminster, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 12 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural near Westminster, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Uniontown Road near Pigtellsburg
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Bertha Irene Grabill

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f.	w.	married.

6.(b) Name of husband or wife: R. Eugene Grabill — 6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): July 23 1886

8. AGE: Years: 61 | Months: 1 | Days: 6 | If less than one day: ...hrs. ...min.

9. Birthplace: Union Bridge, Carroll Co. Md.
(Town, county, and state)

10. Usual occupation: Home - Wife

11. Industry or business:

FATHER — 12. Name: Jacob Harp

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Sabia A. Frushour

15. Birthplace: Maryland

16. Informant: Mrs. R. Eugene Grabill

Address: Westminster R.D.7 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 1, 47 (month) (day) (year)

Cemetery or crematory: Lutheran Cemetery

Location: Uniontown, Carroll Co. Md.

18. Funeral director: J. E. Myers, Jr.

Address: Westminster, Md.

19. 8/29 1947 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29 1947 at 3.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1947 to Aug. 29 1947 and that I last saw h.... alive on Aug. 28, 1947

Immediate cause of death	DURATION
Cerebral embolism	15 hours
Due to: Cardio-vascular disease with myocardial degeneration	about 6 mos.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. Reese Wilbern M. D. or other

Address: Westminster Date signed: 8/29/47

06902

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr 8 mo 16 da
Hospital, institution, or street address (where death occurred) Springfield State Hospital
How long in hospital or institution? 1 yr 8 mo 16 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Frederick
City or town Meyersville (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rosco B Grossnickle

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 8 - 1888

8. AGE: Years 58 | Months 11 | Days 14 | If less than one day ... hrs. ... min.

9. Birthplace Meyersdale (Town, county, and state)

10. Usual occupation Decendent

11. Industry or business

FATHER — 12. Name Charles A Grossnickle
13. Birthplace Meyersdale

MOTHER — 14. Maiden name Lizzie E Buhrman
15. Birthplace Meyersdale

16. Informant Charles Elbert Grossnickle
Address Meyersville

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 4, 1947 (month) (day) (year)
Cemetery or crematory Grossnickle's Cemetery
Location Frederick Co. Md.

18. Funeral director Bittle Bros.
Address Meyersville, Md.

19. Aug. 6 1947 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 1st 1947, at 5-05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 16 1945 to Aug 1st 1947 and that I last saw him alive on Aug 1st 1947

Immediate cause of death	DURATION
Coronary Occlusion	10 minutes
Due to Epilepsy	55 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE J. D. Gaston M.D. M.D. or other
Address Sykesville Date signed 8/1/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

55e

06903

Reg. Dist. No. 71

1. PLACE OF DEATH:
County: Carroll
City or town: Frizzelsburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Frizzelsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Jacob Andrew Haines

3. (b) Social Security Number: None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of ~~husband or~~ wife: Ella M. Haines
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): March 20 - 1862
8. AGE: Years: 85 Months: 4 Days: 13 If less than one day: ..... hrs. ..... min.
9. Birthplace: Carroll County, Md (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Retired
FATHER 12. Name: Samuel A. Haines
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Amanda Bair
MOTHER 15. Birthplace: Maryland
16. Informant: Walter T. Haines
Address: Uniontown, Md.
17. Burial (Burial, cremation, or removal. Which) Date thereof: Aug. 5-1947 (month) (day) (year)
Cemetery or crematory: Pipe Creek Cemetery
Location: Uniontown Road
18. Funeral director: H. W. Hartzler & Sons
Union Bridge & New Windsor Md
19. Aug. 5 1947 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 2 1947 at 4-30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1947 to Aug 2 1947 and that I last saw h.. alive on Aug 1 1947
Immediate cause of death: Coronary Thrombosis — DURATION: Month
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James T. Monroe M. D. or other
Address: Westminster Md Date signed: 8/3/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

06904

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 6 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore, Section A
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3060 Ascention Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: LORRAINE HAMLIN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 8, 1928

8. AGE: Years 18 | Months 7 | Days 24 | If less than one day: hrs. min.

9. Birthplace: Leakville, N.C. (Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business:

FATHER
12. Name: Clarence Hamlin
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Ethel Sander
15. Birthplace: North Carolina

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/4/47 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: Brooklyn Md.

18. Funeral director: Elroy C Wilson
Address: 1003 Bryant Ly Ave

19. 8/1/47 (Date rec'd by registrar) 19 Albert R. Smallwood Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 1, 1947 at 10.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26, 1947 to August 1, 1947 and that I last saw her alive on August 1, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Md. Date signed: 8/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
AUG 1 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

15

06965

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 1 day

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1617 E. Lombard Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Evelyn Bernice Hardy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 18, 1927

8. AGE: Years	Months	Days	If less than one day
20	6	13	hrs. min.

9. Birthplace: Simpson, N. Carolina
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Mc Kinley Hardy
13. Birthplace: Unknown

MOTHER
14. Maiden name: Helen Gatlin
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. Shipped (Burial, cremation, or removal. Which?) Date thereof 9/2/47 (month) (day) (year)

Cemetery or crematory:

Location: Greensburg, N. C.

18. Funeral director: Mr. George Kelson

Address: 1303 Prestman St. Balt. Md.

19. August 31 19 47 (Date rec'd by registrar) Albert R. Smallwood Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 31 19 47 at 2:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30 19 46 to August 31 19 47 and that I last saw her alive on August 31 19 47

Immediate cause of death	DURATION
Tuberculous Peritonitis	June 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other

Address: Henryton, Md. Date signed: 8/31/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93a

06906

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:
County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Rural
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Nannie A. Howard

3.(b) Social Security Number: None

4. Sex: female
5. Color or race: colored
6.(a) Single, married, widowed, or divorced: single
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Sept 16 - 1888
8. AGE: Years: 58 Months: 11 Days: 3 If less than one day: hrs. min.
9. Birthplace: Carroll County, Md. (Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business

FATHER
12. Name: Joseph Howard
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annie Davis
15. Birthplace: Maryland

16. Informant: Altie Hendricks
Address: Union Bridge, Md R.D.

17. Buried (Burial, cremation, or removal, which?) Date thereof: Aug 22 1947 (month) (day) (year)
Cemetery or crematory: Mt. Olive Cemetery
Location: Frederick County Md.

18. Funeral director: D. O. Shriver & Sons
Union Bridge & Westminster, Md

19. Aug 20 1947 (Date rec'd by registrar) P. Eichelman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 19 1947 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 6 1947 to Aug 19 1947 and that I last saw her alive on Aug 19 1947

	DURATION
Immediate cause of death: Acute Myocarditis	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. N. Legg M. D. or other
Address: Union Bridge Date signed: 8-20-1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

06907

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs. 5 mos. 30 days

Hospital, Institution, or street address where death occurred:
Springfield State Hosp.

How long in hospital or institution? 14 yrs. 5 mos. 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Mechanic St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: LEONA HOWSARE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Emory Howsare

6.(c) If alive, give age: unkn. years

7. Birth date of deceased (mo., day, yr.): March 15, 1911

8. AGE: Years	Months	Days	If less than one day
36	4	26	....hrs. ....min.

9. Birthplace: Clarksburg, W. Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: own Home.

FATHER
12. Name: David Keefer
13. Birthplace: unkn.

MOTHER
14. Maiden name: Sarah -----
15. Birthplace: unkn.

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 14, 1947 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cemetery

Location: Sykesville, Md.

18. Funeral director: C.H. Weer

Address: Sykesville, Md.

19. Aug. 14 1947 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10 1947 at 12:55 P.M. (DST)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16, 1941 to August 10 1947 and that I last saw her alive on August 10 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 yr.
Due to	
Due to	
Other conditions	
Psychosis with Epilepsy (Include pregnancy within 3 months of death)	15 yrs.

Major findings of operation: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D.
M.D. or other

Address: Springfield State Hosp. Date signed: 8/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

06908

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 month, 14 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution?: Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. 224 High Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: RUDELL HUMANE

3.(b) Social Security Number:

4. Sex: male
5. Color or race: colored
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Beatrice Humane
6.(c) If alive, give age: 37 years
7. Birth date of deceased (mo., day, yr.): February 13, 1903
8. AGE: Years: 44 Months: 6 Days: 5 If less than one day: ....hrs. ....min.
9. Birthplace: Cambridge, Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: Sylvester Humane
13. Birthplace: Maryland
MOTHER 14. Maiden name: Cassia Roberts
15. Birthplace: Maryland.
16. Informant: Deceased
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 21 1947 (month) (day) (year)
Cemetery or crematory: Waugh Cemetery
Location: Cambridge, Md.
18. Funeral director: Herbert M. Stevens Son
Address: Cambridge Md.
19. 8/18 19 47 (Date rec'd by registrar) Albert R. Stevens Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18, 1947 at 9.45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 4, 1946 to Aug., 18, 1947 and that I last saw him alive on August 18, 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Feb. 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Hyman, M.D. M. D. or other
Address: Henryton, Md. Date signed 8/18/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06909

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mo.
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis San.
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 932 Madison Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Lillian Rivers Jenkins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 25, 1921

8. AGE:

Years	Months	Days	If less than one day
26	6	0	hrs. min.

9. Birthplace: Charleston, S.Carolina (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Joseph Jenkins
13. Birthplace: S. Carolina

MOTHER
14. Maiden name: Susie Rives
15. Birthplace: S. Carolina

16. Informant: patient
Address:

17. Shipped (Burial, cremation, or removal. Which?) Date thereof: August 30 1947 (month) (day) (year)
Cemetery or crematory:
Location: Charleston, S Carolina
18. Funeral director: Mrs Samuel L. Temple
Address: 578 W. Biddle St.

19. 8-25-47 (Date rec'd by registrar) 19 Albert R. Sussman Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 25, 1947, at 1:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 25 1947, to Aug. 25 1947
and that I last saw h alive on 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben H. Homan M.D. M. D. or other
Address: Henryton, Md. Date signed: 8/25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

06910

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? 13 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 W. Hill Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Henry Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1880

8. AGE: Years	Months	Days	If less than one day
67		20	hrs. min.

9. Birthplace Buhl, Alabama
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Alice Unknown

15. Birthplace Unknown

16. Informant Deceased

Address

17. Buried Date thereof 8/20/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Carmel Cemetery

Location Baltimore County, Md.

18. Funeral director Joseph L. Lee

Address 208 W. Montgomery St

19. Aug. 17 1947 Albert R. Sanderson Deputy Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1947 at 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 4 1947 to August 17 1947 and that I last saw him alive on August 17 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	10/26/45
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben Offenman, M.D.
M. D. or other

Address Henryton, Md. Date signed 8/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06911

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 3 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 444 Walton Court
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: BURETT KEATON

3.(b) Social Security Number: 212-05-5268

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Lula Keaton
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): May 4, 1893

8. AGE: Years	Months	Days	If less than one day
54	3	9	....hrs. ....min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Building Constructor
11. Industry or business:

FATHER
12. Name: John Keaton
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Jane Huston
15. Birthplace: North Carolina

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/16/47 (month) (day) (year)
Cemetery or crematory: Arbutus Memorial
Location:
18. Funeral director: Elroy D. Wilson
Address: 1000 Brantly Ave

19. 8/13 (Date rec'd by registrar) 19 47 Albert R. Swanhart Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13, 1947 at 11.00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 10, 1947 to Aug., 13, 1947 and that I last saw h... 1m alive on August 13, 1947

Immediate cause of death	Duration
Pulmonary Tuberculosis	Oct. 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Swan, M. D. M. D. or other
Address: Henryton, Md. Date signed: 8/13/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06912

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 302 N. Pine Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: WADE KENNEDY

3.(b) Social Security Number: 218-09-5566

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 5, 1905

8. AGE: Years	Months	Days	If less than one day
41	11	28	hrs. min.

9. Birthplace: Columbia, South Carloina
(Town, county, and state)

10. Usual occupation: Plumber

11. Industry or business

FATHER
12. Name: John Kennedy
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Esther Hawkins
15. Birthplace: South Carolina

16. Informant: Deceased
Address

17. (Burial, cremation, or removal. Which?) Date thereof 8/6/47 (month) (day) (year)
Cemetery or crematory: Baltimore City Morgue
Location: Baltimore Maryland
18. Funeral director: Mrs Samuel T. Kemply
Address: 578 N. Biddle St.

19. 8/2 (Date rec'd by registrar) 19 47 Albert N. Swarthen Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 2, 19 47 at 4.15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14, 19 47 to August 2, 19 47 and that I last saw h... im alive on August 2, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md Date signed 8/2/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06913

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 4 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2 South George

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph Ignatius Little

3.(b) Social Security Number 212-05-5894

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Linda M. Little 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10 - 1892

8. AGE: Years	Months	Days	If less than one day
54	9	29	hrs. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Lineman: Ret.

11. Industry or business Tel & Tele Co.

FATHER 12. Name Florence P. Little

13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden name Gertrude Brangle

15. Birthplace Maryland

16. Informant Gertrude Hall

Address Westminster, Md.

17. Burial (Burial, cremation, or removal) Date thereof Aug. 12 1947 (month) (day) (year)

Cemetery or crematory Woodlawn Cemetery

Location Westminster, Md.

18. Funeral director H Bankard & Son

Address Westminster, Md.

19. 8/11 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1947, at 11:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945, to August 9 1947

and that I last saw h alive on August 9 1947

Immediate cause of death Pulmonary Tuberculosis

	DURATION
	years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Morrell M. D. or other

Address Westminster Md Date signed 8-11-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

06914

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster 2nd

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster 2nd

(If outside city or town limits, write RURAL and give nearest town)

Street No. 15 Charles

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Albert Magruder

3.(b) Social Security Number 216-05-9260

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Colored	married

6.(b) Name of husband or wife Bertha Murdock

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) March 10 - 1878

8. AGE: Years	Months	Days	If less than one day
69	4	23	..... hrs. ..... min.

9. Birthplace Frederick Co. Md.
(Town, county, and state)

10. Usual occupation Labour

11. Industry or business

FATHER
12. Name Gracson Magruder
13. Birthplace Virginia

MOTHER
14. Maiden name ~~Unknown~~
15. Birthplace " "

16. Informant Bertha Magruder

Address 15 Charles St. Westminster, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof Aug 6 - 1947 (month) (day) (year)

Cemetery or crematory Fairview Cem.

Location Baltimore County Co. Md.

18. Funeral director H. Bankard & Son

Address Westminster, Md.

19. ..... 19.47 H. L. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1947, at 1:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January, 1946, to August 3 1947

and that I last saw him alive on August 3 1947

Immediate cause of death	DURATION
Coronary occlusion	1/2 hr
Due to arteriosclerosis & myocardial degeneration	several yrs.
Due to Auricular Fibrillation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Glenn Preacher M. D. or other

Address Westminster Md. Date signed 8/4/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06915

114d

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany Co.

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route # 2
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mabel Markowitz

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
36			____ hrs. ____ min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace:

MOTHER — 14. Maiden name: Unknown

15. Birthplace:

16. Informant: Hospital records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 1, 1947 (month) (day) (year)

Cemetery or crematory: Jean Memorial Cemetery

Location: Cumberland, Md.

18. Funeral director: Wm. H. Right

Address: Cumberland, Md.

19. Aug 30 1947 (Date rec'd by registrar) A. Harry Steer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25 1947, at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 1947, to August 25 1947 and that I last saw her alive on August 25 1947

Immediate cause of death	DURATION
Lung Abscess	13 days
Due to:	
Due to:	
Other conditions: Schizophrenia	2 mos.

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op.: ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?): ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D.
M. D. or other

Address: Sykesville, Md. Date signed: 8-25-47

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06916

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 5 mos. 7 days.
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Queen Anne's
City or town: Centreville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lottie Moody

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August (?) 1876

8. AGE: Years	Months	Days	If less than one day
71	6		hrs. min.

9. Birthplace: Carmichael, Md. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Joseph Wright
13. Birthplace: Chestertown, Md.

MOTHER
14. Maiden name: Susie Smallwood
15. Birthplace: Chestertown, Md.

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-22-47 (month) (day) (year)
Cemetery or crematory: St. Luke's Cemetery
Location: Sykesville, Md.
18. Funeral director: C. Harry Weer
Address: Sykesville, Md.

19. August 20 19 47 (Date rec'd by registrar) Albert R. Smith Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20 1947, at 12:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13 1945 to August 20 1947 and that I last saw her alive on August 20 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	June 1941
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 8/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06917

932

CERTIFICATE OF DEATH

Reg. Diat. No. 52

1. PLACE OF DEATH:

County: Carroll

City or town: Mt. Airy, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: KATIE B. MULLINIX

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Charles Edward Mullinix

~~deceased~~ 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 31, 1867

8. AGE:

Years	Months	Days	If less than one day
79	9	24	hrs. min.

9. Birthplace: Howard Co. Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Marion Grimm
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rachel Gosnell
15. Birthplace: Maryland

16. Informant: Mrs. Frank Skeggs
Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 8-28-47 (month) (day) (year)

Cemetery ~~or crematory~~: Howard Chapel

Location: Long Corner, Howard Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. Aug 28 1947 (Date rec'd by registrar) Wm D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25 1947, at 8:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 16, 1947, to Aug. 25 1947 and that I last saw h.. alive on Aug 25 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	9
Due to: Arterio - Sclerosis	? yrs
Due to: Hypertension	? yrs
Other conditions: Chr. Myocarditis	? yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Stanley Grabill - M.D.
M. D. or other

Address: Mt. Airy - Md. Date signed: 8/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

06918

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs 2 mo 25 da
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 4 yrs 2 mo 25 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: Howard
City or town: Clarksburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Murphy.

3.(b) Social Security Number:

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): June 1st. 1858
8. AGE: Years: 89 Months: 2 Days: 17. If less than one day: ..... hrs. ..... min.
9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Dependent
11. Industry or business:

FATHER
12. Name: Charles B. Murphy
13. Birthplace: Md.

MOTHER
14. Maiden name: Rebecca Hannahee
15. Birthplace: Md.

16. Informant: Mrs. William Farnum
Address: Clarksburg Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Dec. 18 1947 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Clarksburg, Md.

18. Funeral director: Ernest C. Gartner
Address: Gaithersburg, Md.

19. Aug 19 1947 (Date rec'd by registrar) C. Henry Dawes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 18th. 1947, at 4-45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24 1943 to Aug 18th 1947 and that I last saw her alive on Aug 18th 1947

Immediate cause of death: Cerebral Hemorrhage — 1 wk.
Due to: Chr. Interst. Sclerosis — 7 yrs
Due to: Chr. myocarditis
Other conditions:
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: W. L. Wastler M.D. M. D. or other
Address: Sykesville Md. Date signed 12/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

06919

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster Rural R/2
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred:
Pleasant Valley

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Pleasant Valley
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Laura A. Myers

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: J. Theo. Myers

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 28, 1871

8. AGE: Years	Months	Days	If less than one day
76	2	7	..... hrs. ..... min.

9. Birthplace: Md
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: Joseph Helwig
13. Birthplace: Md

MOTHER
14. Maiden name: Catherine Zepp
15. Birthplace: Md

16. Informant: Mrs. John Pence
Address: Westminster R#2

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Aug. 7, 1947
(month) (day) (year)

Cemetery or crematory: Pleasant Valley
Location: Pleasant Valley, Md.

18. Funeral director: C.O. FUSS & SON
Address: Taneytown, Md.

19. 8/5 19 47
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 4th 19 47, at 6.3A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1st 1947, to Aug. 4 1947
and that I last saw her alive on Aug. 3rd 1947

Immediate cause of death	DURATION
Acute Cardiac Dilatation	12 hrs.
Due to: Cerebral Hemorrhage	10 days
Due to: Arteria Sclerosis	5 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Edna C. Fout M.D.
M. D. or other

Address: Westminster Date signed: 8-6-47

(I) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 415

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06920

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs. 4 months

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 18 yrs. 4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: /

3.(a) FULL NAME: Mary R. Nickerson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: William E. Nickerson

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 11/19/84

8. AGE: Years	Months	Days	If less than one day
62	9	3	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: John Horney

13. Birthplace: Baltimore

MOTHER — 14. Maiden name: Mary Cassidy

15. Birthplace: Baltimore

16. Informant: Record, Springfield State Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-25-47 (month) (day) (year)

Cemetery or crematory: Baltimore Cemetery

Location: Balto. Md.

18. Funeral director: Harry H. Weltzke

Address: 4101 Edmondson ave.

19. Aug. 23 1947 (Date rec'd by registrar) C. Harry Klee Registrar

MEDICAL CERTIFICATION (DST)

20. DATE OF DEATH: 8/22 19 47, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/22 19 29, to 8/22 19 47 and that I last saw h... alive on 8/22 19 47.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3/31/36
Due to:	
Due to:	
Other conditions: Involutional Melancholia (Include pregnancy within 3 months of death)	4/29

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. M. D. or other

Address: Sykesville, Maryland Date signed: 8/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83 b

06923

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH

County Carroll

City or town Sykesville - Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months - 11 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 6 Months - 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Bedford Road - Route 3 -
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Lester Lee O'Neal

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Angela Grise

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 24 - 1898 -

8. AGE:

Years	Months	Days	If less than one day
48	10	24	..... hrs. ..... min.

9. Birthplace Cumberland - Allegany - Md -
(Town, county, and state)

10. Usual occupation Blacksmith

11. Industry or business

FATHER
12. Name George O'Neal
13. Birthplace Ireland

MOTHER
14. Maiden name Ada Bucy
15. Birthplace Unknown

16. Informant Mrs. Angela O'Neal
Address Cumberland - Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-20-47 (month) (day) (year)

Cemetery or crematory Sts Peter & Paul's Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. Aug. 18 1947 C. Henry Wood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1947, at 1:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 6 1947 to August 17 1947 and that I last saw h... alive on August 17 1947

	DURATION
Immediate cause of death Cerebral Embolism and Thrombosis	24 hrs.
Due to Pre-frontal Lobotomy	July 23-47
Due to	
Other conditions Schizophrenia	4 years

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE M. Virginia Beyer M.D.
M. D. or other

Address Sykesville, Md. Date signed Aug. 17-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The front of page is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

06921

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

572

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Thomas Ewinge

3.(b) Social Security Number 217-12-1984

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Rosella Snyder
6.(c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) March 30. 1902

8. AGE: Years	Months	Days	If less than one day
45	4	18	hrs. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name George M. Ewinge
13. Birthplace Carroll Co. Md.
MOTHER 14. Maiden name Martha Caples
15. Birthplace Carroll Co. Md.
16. Informant Mary Ewinge
Address 292 E. Main St. Westminster Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 21-1947 (month) (day) (year)
Cemetery or crematory Deer Park Cemetery
Location Westminster R.D. Md.
18. Funeral director H. Bankard Son
Address Westminster, Md.
19. Aug 20 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 1947, at 11 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__
and that I last saw h__ alive on ____ 19__

	DURATION
Immediate cause of death Brain Tumor	Some yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations Brain Tumor
Date of op. 9/29/46
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James T. Marsh, Deputy Medical Examiner M. D. or other
Address Westminster Md. Date signed 8/20/47

06924

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:
County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Rural
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If a newborn infant, give residence of mother)
State: Maryland County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Clementine L. Perry

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband ~~or wife~~: Arthur A. Perry
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 31 1871

8. AGE: Years 76 | Months 6 | Days 24 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll County, Md.
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business:

FATHER
12. Name: Charles Crumbacker
13. Birthplace: Maryland

MOTHER
14. Maiden name: Anna M. Wood
15. Birthplace: Maryland

16. Informant: Romeo Perry
Address: New Windsor, Md R. D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug-27-47 (month) (day) (year)
Cemetery or crematory: Pipe Creek Cemetery
Location: Uniontown Road

18. Funeral director: H. H. Hartzler & Sons
Address: Union Bridge & New Windsor, Md

19. Aug 27 1947 (Date rec'd by registrar) P. Eckman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 24 1947, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1947, to Aug 24 1947, and that I last saw h... alive on Aug 22 1947

Immediate cause of death: Cerebral Hemorrhage — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: J. H Legg M. D. or other
Address: Union Bridge Date signed 8-24-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The color image is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06925

186a

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Patapsco

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Patapsco

(If outside city or town limits, write RURAL and give nearest town)

Street No. -----

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Wesley Pickett

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Sarah E. Pickett

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 10, 1859

8. AGE: Years	Months	Days	If less than one day
88	1	5	..... hrs. ..... min.

9. Birthplace: Patapsco, Md. (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER

12. Name: Israel Pickett

13. Birthplace: Maryland

MOTHER

14. Maiden name: Susan Fanwell

15. Birthplace: Maryland

16. Informant: Mrs. Howard Arbaugh

Address: Carrollton, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 8/18/47 (month) (day) (year)

Cemetery: Carrollton Church of God

Location: Carrollton, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 8/16 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15 1947, at 3½p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26" 1947, to Aug. 15 1947 and that I last saw him alive on Aug. 15" 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	20 days
Due to Cardio Vascular disease	15 years
Due to	
Other conditions Fell & broke a wall at home, on or about July 24" following stroke" (Include pregnancy within 3 months of death)	

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. T. Billingslea M. D. or other

Address: Westminster, Md. Date signed 8-16-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

06922

Reg. Diat. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mo., 15 days.

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 3 mo., 15 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MATRE POLLITT

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Willa

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1880

8. AGE: Years	Months	Days	If less than one day
67	2	27	hrs. min.

9. Birthplace Wicomico County, Maryland
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Atlantic Mill and Lumber Co.

FATHER 12. Name Andrew Covington Pollitt

FATHER 13. Birthplace Wicomico County, Maryland

MOTHER 14. Maiden name Brown

MOTHER 15. Birthplace Wicomico County, Maryland

16. Informant Springfield State Hosp. records

Address Sykesville, Maryland

17. Burial Date thereof 8-8-47
(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory Parsons Cemetery

Location Salisbury, Maryland

18. Funeral director Holloway & Co.

Address Salisbury, Maryland.

19. Aug. 6 1947 C. Kenny Weir
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1947 at 12:10A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 27 1947 to August 4 1947 and that I last saw h.im alive on August 4 1947

	DURATION
Immediate cause of death Arteriosclerotic heart disease	7 mos. (known)
Due to Psychosis with cerebral arteriosclerosis	7 mos. (known)
Due to	
Other conditions Diabetes mellitus	7 mos. (known)

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph H. Marshall, M.D.
M. D. or other

Address Springfield State Hospital Date signed 8-5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

06926

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 years, 3 months, 25 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 11 years, 3 months, 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rt. #3
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HESTER VIRGINIA POTTS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: William H. Potts
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 26, 1880

8. AGE: Years	Months	Days	If less than one day
66	10	5	..... hrs. ..... min.

9. Birthplace: Cessna, Pennsylvania
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:

FATHER
12. Name: William Sleighter
13. Birthplace: Bedford, Pennsylvania

MOTHER
14. Maiden name: Mary Hall
15. Birthplace: Unknown

16. Informant: Hospital records
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-4-47 (month) (day) (year)
Cemetery or crematory: Springfield Hosp. Cem.
Location: Sykesville, Md.
18. Funeral director: C. Harry Wear
Address: Sykesville, Md.
19. Sept 4 1947 (Date rec'd by registrar) C. Harry Wear Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 31st 1947, at 2:30 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11th 1945, to August 31st 1947
and that I last saw her alive on August 30th 1947

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	about 3 years
Due to:	
Due to:	
Other conditions: Schizophrenia, hebephrenic type	more than 12 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Irene Hechmer M.D.
M. D. or other
Address: Springfield State Hospital Date signed: 8-31-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06927

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Hampstead Md Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, institution, or street address where death occurred:
near Greenmount
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Hampstead Md Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: near Greenmount
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Jacob William Reed.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married.

6.(b) Name of husband or wife: Laura Ellen Reed
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Apr. 15 1881

8. AGE:

Years	Months	Days	If less than one day
66.	3	22	hrs. min.

9. Birthplace: Hampstead Md
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Agriculture.

FATHER
12. Name: Edmund Reed.
13. Birthplace: Mary Land.

MOTHER
14. Maiden name: Catherine Smith.
15. Birthplace: Maryland

16. Informant: Laura Ellen Reed
Address: Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 9/47 (month) (day) (year)
Cemetery or crematory: Greenmount
Location: Carroll Co Md
18. Funeral director: Eden & Tipton
Address: Hampstead Md

19. Aug 8 1947 (Date rec'd by registrar) Mrs. W. P. S. Deaver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 7 1947, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 1947, to Aug 7 1947, and that I last saw ... alive on Aug 5 1947.

Immediate cause of death: Chronic Myocarditis — DURATION: 7

Due to: Generalized and Cerebral Arteriosclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: — Injured at work? —

23. SIGNATURE: Jas E Bush MD
M. D. or other
Address: Hampstead Md Date signed: 8-7-47

VS A-15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06928

93d

Reg. Dist. No. 83

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

(M) (I)

1. PLACE OF DEATH:
County: Carroll
City or town: Gaither
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Gaither
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: GEORGE DANIEL RHEUBOTTOM

3.(b) Social Security Number: 722-05-5298

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of ~~husband or~~ wife: Bessie S. Rheubottom
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Oct. 22, 1869

8. AGE: Years 77 | Months 9 | Days 14 | If less than one day: hrs. min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: B. & O. R.R.

FATHER
12. Name: Samuel Rheubottom
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Cook
15. Birthplace: Maryland

16. Informant: Mrs. Bessie S. Rheubottom
Address: Gaither, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 8-9-47 (month) (day) (year)
Cemetery ~~or crematory~~: White Rock
Location: Berrett, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. Aug. 9 19 47 Edna M. Hewitt Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 6 19 47, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 19 46, to Aug 6 19 47
and that I last saw h~~im/er~~ alive on Aug 5 19 47

Immediate cause of death: Cardio Vascular
Due to: disease
Due to:
Other conditions:

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. A. Bruno M.D. M. D. or other
Address: Sykesville, Md. Date signed 8/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

06929

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 264 E. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war World War I

3.(a) FULL NAME Raymond E. Rhoten

3.(b) Social Security Number 214-01-0544

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Nola M. Rhoten
6.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) September 8, 1893

8. AGE: Years	Months	Days	If less than one day
53	11	22	..... hrs. ..... min.

9. Birthplace Carroll County, Md.
(Town, county, and state)
10. Usual occupation Dairy manager
11. Industry or business

FATHER
12. Name Charles B. Rhoten
13. Birthplace Maryland

MOTHER
14. Maiden name Martha A. Houck
15. Birthplace Maryland

16. Informant Mrs. Raymond E. Rhoten
Address Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 9/2/47 (month) (day) (year)
Cemetery or crematory Westminster Cemetery
Location Westminster, Md.

18. Funeral director J. Francis Reese
Address Westminster, Md.

19. 9/1 (Date rec'd by registrar) 19 47 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30th 19 47 at 1:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h[illegible] alive on Aug. 30th 19 47

Immediate cause of death	DURATION
Coronary Occlusion	4 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Westminster Date signed 8-30-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06930

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs., 8 mos., 4 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 8 yrs., 8 mos., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: Jefferson
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: ARTHUR RICE

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	divorced

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 24, 1874

8. AGE: Years	Months	Days	If less than one day
73	6	29	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: farmer
11. Industry or business
12. FATHER — Name: William T. Rice
13. FATHER — Birthplace: Maryland
14. MOTHER — Maiden name: Susan Ronston
15. MOTHER — Birthplace: Maryland
16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/25/47 (month) (day) (year)
Cemetery or crematory: Methodist Cemetery
Location: Jefferson, Maryland
18. Funeral director: M. R. Etchison and Son
Address: Frederick, Maryland
19. 25 Aug 1947 (Date rec'd by registrar) Harry Steer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22 19 47, at 1:29 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1947, to August 22 1947
and that I last saw him alive on August 22 1947

Immediate cause of death	DURATION
Pneumonia, hypostatic	3 days
Due to: Cerebral accident	12 days
Due to:	
Due to:	
Other conditions: Schizophrenia	1918
Arteriosclerosis	1938

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M.D. or other
Address: Springfield State Hospital Date signed 8/22/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66931

Reg. Dist. No. 74

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 10 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 1 month, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2000 Wetheredsville Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: BERNARD PIUS ROHR

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	WIDOWER

6.(b) Name of husband or wife: Mary Catherine King (deceased) 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 10/30/79

8. AGE: Years	Months	Days	If less than one day
67	9	11	hrs. min.

9. Birthplace: Maryland (Baltimore) (Town, county, and state)

10. Usual occupation: Office Work

11. Industry or business:

FATHER — 12. Name: Joseph A. Rohr; 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary Jane Kennedy; 15. Birthplace: Maryland

16. Informant: Record, Springfield State Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 14 1947 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Baltimore

18. Funeral director: E. Arnold

Address: 3911 Liberty Hgts Ave

19. Aug. 13 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION (DST)

20. DATE OF DEATH: 8/11 1947 at 11:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/1/ 1947 to 8/11 1947 and that I last saw him alive on 8/11 1947

Immediate cause of death	DURATION
Gastric Hemorrhage	5 days
Due to: Gastric malignancy, type undetermined	unknown
Due to:	
Other conditions: Schizophrenia, paranoid type (Include pregnancy within 3 months of death)	Since 1916

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. M. D. or other

Address: Sykesville, Maryland Date signed: 8/11/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

66932

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:

County: Carroll

City or town: Manchester 3rd R.D. # 1
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. # 1
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Leroy Shaffer

3.(b) Social Security Number: 363-05-9661

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	M

6.(b) Name of husband or wife: Dorothy (Ferriss)

7. Birth date of deceased (mo., day, yr.): November 14, 1894 — 6.(c) If alive, give age: 43 years

8. AGE:

Years	Months	Days	If less than one day
52	9	11	hrs. ... min.

9. Birthplace: Carroll Co. Md.
(Town, county, and state)

10. Usual occupation: Retired Farmer 1 year

11. Industry or business:

FATHER
12. Name: John Wesley Shaffer
13. Birthplace: Carroll Co. Md.

MOTHER
14. Maiden name: Jane Elizabeth Fowler
15. Birthplace: Carroll Co. Md.

16. Informant: Mrs. Ethel Shaffer
Address: Manchester Md. R.D. # 1

17. (Burial, cremation, or removal, Which?) Burial — Date thereof: Aug 28, 1947 (month) (day) (year)

Cemetery or crematory: Union Cemetery

Location: Manchester Md.

18. Funeral director: William A. Grosser

Address: Hanover Pa. 205 Carlisle St.

19. Aug. 27 1947 (Date rec'd by registrar) — Mrs. H. R. S. Denner, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25, 1947, at 10:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to Aug. 25 1947 and that I last saw h... alive on Aug. 25 1947

Immediate cause of death	DURATION
Cerebral Hemmorrhage	3 hrs
Due to: Hypertension and Cardio-Vascular disease	8 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ... Injured at work?

23. SIGNATURE: Maurice C Carter Jr. M.D. or other

Address: Hampstead Md. Date signed: 8/26/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66933

Reg. Dist. No. 77

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Carroll

City or town: Hampstead Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 71 yrs.

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Hampstead Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Willella Maxwell Stansbury.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife: Benjamin Franklin Stansbury

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb 28, 1858

8. AGE: Years: 89 | Months: 6 | Days: 0 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Wm Maxwell

13. Birthplace: Scotland

MOTHER — 14. Maiden name: Elinor Kelly

15. Birthplace: Ireland

16. Informant: Miss Mai Stansbury

Address: Hampstead, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 30/47 (month) (day) (year)

Cemetery or crematory: Hampstead

Location: Hampstead Md

18. Funeral director: Edgar Fuhrman

Address: Hampstead Md

19. Aug 29 1947 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 28 1947, at 12 50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 1947, to Aug 28 1947

and that I last saw h.. alive on August 28 1947

	DURATION
Immediate cause of death: Chronic Myocarditis	
Due to: Generalized Arteriosclerosis	
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. ....

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury: Injured at work?

23. SIGNATURE: Lewis E. Beard M.D. M. D. or other

Address: Hampstead Md Date signed: 8-28-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

06934

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ hours

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MARY ANN STAUBITZ

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Frank Thomas Staubitz

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 21, 1879

8. AGE:

Years	Months	Days	If less than one day
67	8	0	..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: --

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mary Ann Ruppert
15. Birthplace: Virginia

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/23/47 (month) (day) (year)

Cemetery or crematory: Freedom

Location: Eldersburg, Carroll Co. Md

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. Aug. 21, 1947 (Date rec'd by registrar) Albert R. Shrandhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 21, 1947 at 1:00A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 20, 1947 to Aug. 21, 1947 and that I last saw her alive on August 21, 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	12 hrs.
Due to: Hypertension	Unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. (M. D. or other)

Address: Henryton, Md. Date signed 8-21-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

06935

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

CERTIFICATE OF DEATH

Reg. Diat. No. 81

1. PLACE OF DEATH:
County Carroll
City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carrol
City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Cora A. Stauffer

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband ~~or wife~~ L. E. Stauffer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 7-1863

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
84	0	30		

9. Birthplace Carroll County Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business At home

FATHER
12. Name Philip Stauffer
13. Birthplace Maryland

MOTHER
14. Maiden name Alice Sheppard
15. Birthplace Maryland

16. Informant L. E. Stauffer
Address Union Bridge Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 9-1947 (month) (day) (year)
Cemetery or crematory Pipe Creek Cemetery
Location Uniontown Road
18. Funeral director H. W. Hartzler & Sons
Address Union Bridge & New Windsor, Md

19. Aug. 9, 1947 (Date rec'd by registrar) Weishaar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1947 at 2 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1947 to Aug 6 1947 and that I last saw h~~er~~ alive on August 5 1947

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. H. Legg M. D. or other
Address Union Bridge Date signed 8-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

06936

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 4 Days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1024 Rutland Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

William Still

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 6, 1894

8. AGE: Years	Months	Days	If less than one day
53	6	13	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Roofer

11. Industry or business:

FATHER
12. Name: Jessie Still
13. Birthplace: Virginia

MOTHER
14. Maiden name: Ellen Harris
15. Birthplace: Virginia

16. Informant: Sister: Mrs. Lula Pugh
Address: 1811 E. Biddle St. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-22-1947 (month) (day) (year)

Cemetery or crematory: Mt Calvery Cem.

Location: Anne Arendal Co.

18. Funeral director: Rayner Sanders

Address: 1412 E. Preston St.

19. August 19 19 47 (Date rec'd by registrar) Albert R. Grandham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19, 19 47 at 11:55 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 19 47 to August 19 19 47 and that I last saw him alive on August 19 19 47

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Jan. 1947

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Kwan, M. D.
M. D. or other

Address: Date signed:

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C

06937

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll County

City or town: Springfield State Hospital, Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7-8-37 till 8-24-47

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? from 1937-1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: 1807 Penrose Ave.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Baltimore

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary M. Strickler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	

6.(b) Name of husband or wife: Ulrich Strickler

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr. 15, 1880

8. AGE: Years	Months	Days	If less than one day
67	4	10	hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Canvasser

11. Industry or business:

FATHER 12. Name: Mathias Wise

FATHER 13. Birthplace: Austria

MOTHER 14. Maiden name: Eva Null

MOTHER 15. Birthplace: Ireland

16. Informant: Valentine Strickler

Address: 1807 Penrose Ave

17. (Burial, cremation, or removal. Which?) Burial Date thereof 8-28-47 (month) (day) (year)

Cemetery or crematory: Loudon Park National

Location: Baltimore

18. Funeral director: George A. Farley

Address: Fulton Ave. & Fayette St.

19. (Date rec'd by registrar) Aug. 29 1947 C. L. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24-8 1947, at 3 30 (hour) A.M. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.... to ..... 19.....

and that I last saw h-- alive on 23-8 1947

Immediate cause of death	DURATION
General exhaustion	
Due to: Marasmus, decompensated	
Due to: Heart failure	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dr. H. Salomon M. D. or other

Address: Springfield State Hospital Date signed 24-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V9 A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46e

06938

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 34 W. Green St.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. 34 W. Green Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lewis Abraham Stultz

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband~~ or wife Rose Fogle

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10 - 1876

8. AGE:

Years	Months	Days	If less than one day
71	11	28	hrs. min.

9. Birthplace Carroll County, Maryland
(Town, county, and state)

10. Usual occupation retired Farmer

11. Industry or business farmer

FATHER
12. Name David Stultz
13. Birthplace Maryland

MOTHER
14. Maiden name Elizabeth Stultz
15. Birthplace Maryland

16. Informant Thomas D Stultz

Address New Windsor, Maryland

17. Burial Date thereof Aug 17-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Church of God Cemetery

Location Uniontown, Maryland

18. Funeral director D D Hartzler & Sons

Address New Windsor & Union Bridge Md.

19. 8/16 1947 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1947 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to August 14 1947

and that I last saw him alive on August 14 1947

Immediate cause of death	DURATION
Carcinoma (Prostate)	?
" (Metastasis)	
" (Ileum)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op

Autopsy results Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Jennette M.D.
M. D. or other

Address Westminster Md Date signed 8-16-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A-15 9-45-15M

06939

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940a

CERTIFICATE OF DEATH

Reg. Dist. No. 79

1. PLACE OF DEATH:

County: Carroll

City or town: Middleburg
(If outside city or towo limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Carroll

City or town: near Middleburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Scott W. Swarts

3. (b) Social Security Number

none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1885

8. AGE: Years	Months	Days	If less than one day
61	9	3	..... hrs. ..... min.

9. Birthplace: Spring Water N.Y.
(Town, county, and state)

10. Usual occupation: Farm Manager

11. Industry or business

FATHER — 12. Name: Jacob O. Swarts
13. Birthplace: N.Y.

MOTHER — 14. Maiden name: Mary V. Weidman.
15. Birthplace: N.Y.

16. Informant: Mrs. Alta Swarts
Address: Danville, N.Y.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 21, 1947. (month) (day) (year)

Cemetery or crematory: Pleasant Valley

Location: Spring Water, N.Y.

18. Funeral director: C. O. FUSS & SON
Address: Taneytown, Md.

19. Aug. 20 1947 (Date rec'd by registrar) Fanny M. Kiser Powell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 18 1947, at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 17 1947, to Aug. 18 1947 and that I last saw h... alive on Aug. 18 1947

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. H. Legg
M. D. or other

Address: Union Bridge Date signed 8-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06940

932

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 years

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 33 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary Tulley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 31, 1876

8. AGE: Years	Months	Days	If less than one day
70	7	2	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Supervisor of nurses

11. Industry or business

FATHER — 12. Name: unknown

FATHER — 13. Birthplace: unknown

MOTHER — 14. Maiden name: unknown

MOTHER — 15. Birthplace: unknown

16. Informant: friends, Mrs. Frank Ely

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-5-47 (month) (day) (year)

Cemetery or crematory: Springfield Cemetery

Location: Sykesville, Md.

18. Funeral director: C. Harry Wine

Address: Sykesville, Md.

19. Aug 4 1947 (Date rec'd by registrar) C. Harry Wine Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 2, 1947, at 8.30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26, 1947, to August 2, 1947 and that I last saw her alive on August 2, 1947

Immediate cause of death	DURATION
Pulmonary embolism	1 day
Due to: Chronic myocarditis and myocardial degeneration	about 4 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Irene Hitchman, M.D. M. D. or other

Address: Springfield State Hospital Date signed 8-2-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06941

94a

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Finksburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, institution, or street address where death occurred: Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Finksburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Joseph Maurice Walter

3. (b) Social Security Number: 218-01-7027

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertha Walter

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 29, 1882

8. AGE: Years	Months	Days	If less than one day
54	9	25	hrs. min.

9. Birthplace: Emmitsburg Md. (Town, county, and state)

10. Usual occupation: Tool maker Machinist

11. Industry or business: Anchor Post Fence

FATHER — 12. Name: Wm. Walter

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Mary Hopp

MOTHER — 15. Birthplace: Md.

16. Informant: Bertha Walter

Address: Finksburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 27, 1947 (month) (day) (year)

Cemetery or crematory: St. Anthony Cemetery

Location: Emmitsburg, Md.

18. Funeral director: J. F. Eline & Sons

Address: Reisterstown, Md.

19. 8/26 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 24 1947 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 8 1947, to Aug. 24 1947 and that I last saw him alive on Aug. 24. 1947

Immediate cause of death	DURATION
Coronary occlusion -	
Due to Coronary sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James T. Maund M. D. M. D. or other

Address: Westminster Md. Date signed: 8/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06942

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 15M

1. PLACE OF DEATH:

County Carroll

City or town Manchester Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Weeks.

Hospital, Institution, or street address where death occurred:
Long View Nursing Home

How long in hospital or institution? 2 wks.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County —

City or town Baltimore Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3022 Belmont ave.
(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME George Edward Wareheim.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Laura A. Wareheim

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1858

8. AGE: Years 89 | Months 5 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace Middletown, Md.
(Town, county, and state)

10. Usual occupation Jeweler

11. Industry or business Self

FATHER
12. Name Henry S. Wareheim
13. Birthplace Md.

MOTHER
14. Maiden name Matilda Menges
15. Birthplace Md.

16. Informant Miss Esta Wareheim

Address 3022 Belmont Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/8/47 (month) (day) (year)

Cemetery Woodlawn

Location Woodlawn, Md.

18. Funeral director WM. J. TICKNER & SONS INC.

Address North & Pa. Aves. Balto. 17, Md.

19. 8-7 1947 A.W. Hedrick M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1947, at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23 1947, to Aug 6 1947

and that I last saw h.. alive on August 5 1947

Immediate cause of death — DURATION

Cerebral Hemorrhage 48 hours

Due to .....

Due to Coronary Sclerotic Cardio-Vascular Disease .....

Other conditions Senility.

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury — Injured at work? —

23. SIGNATURE Joseph E. Bushman M. D. or other

Address Hampstead Md. Date signed 8-6-47

06945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 mos. 25 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Caroline
City or town: Goldsboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Calfreda Warner

3.(b) Social Security Number: 213-22-6079

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 18, 1927

8. AGE: Years	Months	Days	If less than one day
20	3	10	..... hrs. ..... min.

9. Birthplace: Greensboro, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: William Warner
13. Birthplace: Unknown

MOTHER
14. Maiden name: Sarah Brown
15. Birthplace: Unknown

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 31 (month) 47 (day) (year)
Cemetery or crematory: Union
Location: Near Greensboro Md

18. Funeral director: Raymond B. Rawlings
Address: Greensboro Md.

19. August 28 19 47 (Date rec'd by registrar) Albert R. Smallwood Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 28 19 47 at 7:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 3 19 46 to August 28 19 47 and that I last saw her alive on August 28 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md Date signed: 8/28/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for the change of year of birth and age is shown on

06943

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

FILM No. G 112 AUG 28 1947

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Patapsco
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 434 W. Franklin St.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Charles August Weaver

3.(b) Social Security Number: 705-10-5539

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Julia Taylor Weaver

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): March 13, ~~1896~~ 1898

8. AGE: Years	Months	Days	If less than one day
57 ~~51~~	5	1	hrs. min.

9. Birthplace: Patapsco, Maryland (Town, county, and state)

10. Usual occupation: retired R.R. Yard Foreman

11. Industry or business

FATHER
12. Name: George Weaver
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elizabeth Smith
15. Birthplace: Maryland

16. Informant: Mrs. Julia T. Weaver
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/17/47 (month) (day) (year)

Cemetery or crematory: Wesley Chapel Cemetery

Location: near Hampstead, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Maryland

19. 8/15 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14 19 47 at 6 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to Cardiosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: James F. Marsh Deputy Medical Examiner M. D. or other

Address: Westminster Md Date signed 8/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06944

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months, 26 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 10 months, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 26 North Monroe Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

John F. Welch

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	?

6.(b) Name of husband or wife: ?

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): ?

8. AGE: Years	Months	Days	If less than one day
82 ?			____ hrs. ____ min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: ?

11. Industry or business

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Records, Springfield State Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-26-47 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Balto. Md.

19. Funeral director: F. B. Wilkes

Address: 1300 Eutaw Place

19. Aug 24 1947 (Date filed by registrar) C. Harry Zeve Registrar

MEDICAL CERTIFICATION (DST)

20. DATE OF DEATH: 8/23 19 47 at 2:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/27 19 46 to 8/23 19 47 and that I last saw him alive on 8/23 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	11 years
Due to	
Due to	
Other conditions: Senile Psychosis, simple deterioration (Include pregnancy within 3 months of death)	11 months

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of Injury ____ Injured at work?

23. SIGNATURE: Arnold N. Eichert, M.D.
M. D. or other

Address: Sykesville, Maryland Date signed: 8/23/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06946

52 dy

Reg. Dist. No. 81

1. PLACE OF DEATH:
County Carroll
City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Frank B. Whitehill

3.(b) Social Security Number 214-22-3133

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2-1878

8. AGE: Years	Months	Days	If less than one day
68	11	16	hrs. min.

9. Birthplace Frederick County, Md.
(Town, county, and state)
10. Usual occupation Cattle Dealer
11. Industry or business
FATHER 12. Name John Whitehill
13. Birthplace Maryland
MOTHER 14. Maiden name Susan Barnes
15. Birthplace Maryland
16. Informant Miss Margaret Whitehill
Address Union Bridge, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 21-1947 (month) (day) (year)
Cemetery or crematory Evergreen Cemetery
Location Uniontown, Md.
18. Funeral director C. O. Hartley & Sons
Address Union Bridge & New Windsor, Md
19. Aug 20 19 47 (Date rec'd by registrar) P. Eichman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 19 47 at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 19 47 to Aug 18 19 47
and that I last saw him alive on Aug 18 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James T. Marsh M. D. or other
Address Westminster Md Date signed 8/20/47

VS A15.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06947 B.

93d

Reg. Dist. No.

1. PLACE OF DEATH:

County: Carroll

City or town: Springfield State Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos., 29 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 3 mos., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore Co.

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3012 Putty Hill, Baltimore-14
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Bernard Ferdinand Wienhold

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Margaret Engelmen

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 16, 1866

8. AGE: Years: 81 Months: 3 Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore City, Md.
(Town, county, and state)

10. Usual occupation: Driver of a delivery truck

11. Industry or business:

FATHER
12. Name: Frederick Wienhold
13. Birthplace: Holland

MOTHER
14. Maiden name: Nancy Parker
15. Birthplace: Pennsylvania

16. Informant: Hospital records
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/20/47 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Belair Road, Balto: Md.

18. Funeral director: George J. Ruth, Inc.

Address: 1735 Harford Avenue

19. Aug 18 1947 (Date received by registrar) T. W. Hubbard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 16, 1947, at 11:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18, 1947, to Aug. 16, 1947 and that I last saw him alive on Aug. 16, 1947

Immediate cause of death	DURATION
Generalized arteriosclerosis	?
Arteriosclerotic heart disease	?
Due to: Terminal bronchopneumonia	2 days
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	3-4 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M. D. M. D. or other

Address: Springfield State Hospital Date signed:

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06948

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:

County CARROLL

City or town HENRYTON (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: MD. TUBERCULOSIS SANATORIUM

How long in hospital or institution? 3 MOS., 19 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 811 Vine Street (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME WILLIE WILLIAMS

3.(b) Social Security Number 216-12-8351

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	COL.	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 12, 1902

8. AGE:	Years	Months	Days	If less than one day
	44	8	5	hrs. min.

9. Birthplace New Bern, N.C. (Town, county, and state)

10. Usual occupation laborer

11. Industry or business

FATHER 12. Name Lewis Williams

13. Birthplace N.C.

MOTHER 14. Maiden name Mary Deas

15. Birthplace N.C.

16. Informant Reuben Hoffman, M.D.

Address Henryton, Md.

17. Burial, cremation, or removal Which Date thereof 8/21/47 (month) (day) (year)

Cemetery or crematory Randall Cemetery

Location R. Brown

18. Funeral director

Address 108. W. Monigomery St

19. Aug. 17 19 47 (Date rec'd by registrar) Albert R. Swanhart Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 19 47 at 8:00 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 28 19 47 to Aug. 17 19 47 and that I last saw him alive on Aug. 17 19 47

Immediate cause of death	DURATION
Pulmonary tuberculosis	4/9/47
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Henryton, Md. Date signed 8-17-47